

Sustainable Empowerment of Women and Mortality Statistics in India: Impact on Women's Health and Analysis

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Abstract: Achieving gender equality and women's empowerment is integral to each of the 17 Sustainable Development Goals; pressing challenges of our time is from economic crisis and lack of health care, to climate change, violence against women and escalating conflicts. Only by ensuring the rights of women and girls across all the goals will we get to justice and inclusion, economies that work for all, and sustaining our shared environment now and for future generations. The purpose the paper explores the definition of sustainable development of women with empowerment concept and consciousness of women's health as well as to achieve the gender equality of Millennium Development Goals of United Nations as India is also a signatory of these goals. Gender Plays a key role in Health-related decisions which are made by male gender in Indian society/families in particular with rural families. Further the paper explore the women the importance of empowerment of women to improve the mortality trends in India and impact of mortality on women's health which needs is an importance aspect in eliminating the gender inequality which are moral imperatives and fundamental human rights. Women access to health care and their ability to achieve good health is the main goal and policies have been introduced by Government of India and also by State Government for improving the standards of health care of the people and in particular women's mortality. In conclusion the paper discusses the Human Development Trends of the mortality rate in India and to improve the mortality rates of women by government by securing the health rights and also investing in health sectors.

Keywords: Empowerment, Health, Mortality, Sustainability, Women

Introduction

Every day in 2010, about 800 women died due to complications of pregnancy and child birth, including severe bleeding after childbirth, infections, hypertensive disorders, and unsafe abortions. Out of the 800, 440 deaths occurred in sub-Saharan Africa and 230 in Southern Asia, compared to five in high-income countries. The risk of a woman in a developing country dying from a pregnancy-related cause during her lifetime is about 25 times higher compared to a woman living in a developed country. Maternal mortality is a health indicator that shows very wide gaps between rich and poor, both between countries and within them. Carl Haub (2007) Gender differences in mortality and life expectancy vary by country. But in most countries, men live shorter lives than women (see figure). In Russia, for instance, the difference between male and female life expectancy is 13 years (59 vs. 72). In other countries, such as the United States, the male disadvantage is smaller: 5 years (75 vs. 80). And in some countries, such as Afghanistan, there is little or no male disadvantage (42 vs. 42).

While women rate their health worse than men and visit the hospital more often than men from early adolescence to late middle age, they are less likely to die at each age. This paradox can be explained at least in part by differences in the prevalence of chronic conditions men and women face. Sandra Yin (2007) women experience higher rates of pain (headache, arthritis), and some respiratory conditions, including bronchitis, asthma, and lung problems not related to cancer. They are also much more likely to suffer from reproductive cancers, hypertension, vision problems, and depression. Men are more likely to suffer from hearing loss; smoking-related ailments, such as emphysema and respiratory cancer; and circulatory problems including cardiovascular disease and diabetes.

However, women and men with the same chronic conditions have the same self-rated health. Yet men with respiratory cancer, cardiovascular disease, and bronchitis are more likely to die than women with these conditions. This implies that men may experience more severe forms of these conditions. Researchers have found that conditions associated with excess male hospitalizations and deaths tend to be smoking-related. Indeed, men with smoking-related conditions are significantly more likely to die in two years than women with the same conditions. This may be the case, because typically, men are exposed to smoking for a longer time on average than women.

To attain the gender health and promote the gender equality we need to focus on increasing attention to gender equity/equality goals in reproductive health (RH) and HIV/AIDS programs promotes respect for the fundamental needs and rights of individuals and communities. Gender integration makes programs and policies responsive to the social, economic, cultural, and political realities that constrain or enhance reproductive health and satisfaction.

Bird (2012) in his paper 'Changing Gendered Patterns of Morbidity and Mortality' examine gender differences in health and mortality, substantial knowledge gaps remain when it comes to informing interventions and policy. As Verbrugge and Wingard (1987) note, much of women's higher morbidity and lower mortality compared to men can be explained by gender differences in disease prevalence. In most industrialized nations, men develop more life-threatening conditions (for example, cancer and cardiovascular disease) at younger ages than do women. Women's mortality advantage is a fairly recent development. When life expectancy was lower, women did not typically outlive men and were at significant risk of dying in childbirth or subsequently from related infections. In fact, at the turn of the 20th century, the United States exhibited the public health characteristics similar to that of a developing country today: the three leading causes of death were infectious diseases: pneumonia, tuberculosis and infant diarrhoea (Omran, 1977). In 1901, the difference in life expectancy for males and females at birth was less than three years (48.3 vs 51.1 years for whites and 32.5 vs 35.0 for blacks) (Department of Commerce, 1921).

Review of Literature

Miukesh Eswarn (2002) in their paper titled 'The Empowerment of Women, Fertility, and Child Mortality: Towards a Theoretical Analysis', has argued that it is premised on the assumption that, in the provision of adequate support for their old age through children, the women of developing countries bear a greater share of the cost than do their spouses. It has been shown here, using an asymmetric Nash Bargaining framework, that the empowerment of women - which increases the bargaining power of wives relative to their husbands - results in a decline in fertility and in the mortality rate of children. It has been argued here that empowerment of women bestows the further benefit to society of increasing the incentives of parents to educate their children. The return on the education of children clearly increases with their survival probability, and this probability is higher when women are more empowered to make decisions within the household. To protect their greater investment in the education of their children, parents would be induced to invest even more in the healthcare of the children. This decline in the mortality rate of children would lead parents to curtail that part of their fertility which is meant for insurance purposes. Thus the empowerment of women emerges as potentially a very strong factor in hastening the demographic transition of a developing country.

Yibeltal Kiflie Alemayehu et. al. (2015) in their paper The Role of Empowerment in the Association between a Woman's Educational Status and Infant Mortality in Ethiopia: Secondary Analysis of Demographic and Health Surveys set the objective of their study was to explore the role of woman's empowerment and household wealth in the association between a woman's educational status and infant mortality.

Women hold primary responsibility for the care of children throughout the world. Accomplishing this responsibility to achieve better health outcomes for their children requires both the availability of resources in a household and a certain level of control over available resources. In this regard, we found that the association between woman's education and infant death is mediated by woman's empowerment but not by household wealth. Socioeconomic status at national, sub-national, household, and individual levels explains a significant portion of variation in infant mortality. This suggests that an increase in a woman's own education may decrease the risk of infant death, presumptively because of the power it gives her in making household decisions rather than the additional wealth it brings to the household. This may indicate the potential of empowering women to improve infant survival through maximal use of already existing household resources in a developing country setting. In Ethiopia, woman's education is inversely associated with infant death, and this association is mediated by a mother's household-level empowerment status and moderated by household wealth. While maintaining the long term vision of women's education helps to sustainably reduce infant mortality, empowering women at household level has the potential to

improve material circumstances and child health outcomes in the short term. Improving household wealth is an important condition but not sufficient to reduce infant mortality by itself; woman's power plays vital role in translating available resources into child health outcomes. Poverty reduction measures should therefore be complemented by woman education and empowerment efforts which in return can contribute to infant survival.

Prata et al. (2017) Fertility decline does seem to be linked to better well-being for women, but patriarchal gender norms can inhibit its impact. Just as empowerment seems to affect health, women who start childbearing later are more likely to show more gender equitable attitudes. When mothers are empowered, their daughters are less likely to have sex at a young age, but they still have the same rates of unintended pregnancies. Among slum women, higher rates of expressed empowerment are correlated with lower levels of mistreatment by health providers during delivery. Providers who are themselves empowered can actively expand women's access to abortion, even in countries where it is legally restricted. Overall, gender-integrated interventions related to family planning and maternal health are not evaluated with sufficiently consistent and validated measures of women's empowerment to know if they are having the intended impact. Women who are more empowered are more likely to use skilled birth attendants, which could be expected to lower maternal mortality. However, in Africa, women's empowerment may not lead to changes in maternal mortality rates if health systems remain corrupt. Litigation can be an empowering strategy globally if it reframes maternal mortality as discriminatory and changes public norms.

In their paper, Dunn et al. analyzed the impact of international and domestic decisions on access to high quality reproductive healthcare, showing that human rights litigation can support other efforts to achieve better care for women. They discussed several case studies in which national courts in countries such as Uganda, as well as international treaty bodies, have challenged traditional structures that discriminate against women. They argued that human rights litigation is a women's empowerment strategy that needs greater attention, because they found that cases like *Alyne v. Brazil* brought public awareness about discrimination against poor or marginalized women in the health system and provided leverage to civil society to make changes. Indeed, human rights litigation often complements political and social movements and provides momentum to bring change.

According to IIASA postdoctoral research scholar Nandita Saikia, among the authors of this study, the period (2000-2005) was chosen because it had the most consistent district-level data. She added that the findings of the study reinforce the need to directly address the issue of gender discrimination, in addition to "encouraging social and economic development for its benefits on Indian women." Based on statistical and mapping analyses, a close association was observed between excess female under-five mortality and socio-economic variables at district level, such as relative underdevelopment and reliance on agricultural and household work. Researchers also found a decreased prevalence of gender bias among Muslims and Scheduled Tribe communities. Across the 640 Indian districts, excess female under-five mortality rate was highest among Hindus, consistent with a higher preference for sons among the religious group. Gender equality, according to study coauthor Christophe Guilmoto, is not limited to the right to education, employment and political representation. "It is also about care, vaccination and nutrition of girls and ultimately survival."

According to the Results from Phase 1 of NFHS-4 a brief exposition of the trends in health, fertility, status of women, nutrition and child mortality between 2005-06 and 2015-16 as have emerged from the National Family Health Survey in 17 states. Ram (2016) as briefly described, NFHS-4 results for 2015-16 from the 17 states/UTs surveyed in Phase 1 clearly indicate a major improvement in some of the crucial population and health indicators since the last survey in 2005-06, including spousal violence and women's participation in decision-making. The encouraging features related to the household environment has been the increase in households electrified, better access to improved sources of drinking water and sanitation, and more use of clean fuel for cooking. Besides, in most states fertility underwent a further decline, reaching the replacement level or below. Surprisingly, the current use of modern contraceptive methods decreased in most states over the last decade. Child nutrition and vaccination coverage showed an improvement in most states, but concerns remain with rural areas. Adult health will be an important issue to address in the future, particularly related to obesity and high blood glucose levels, the use of tobacco and alcohol, as well as violence against women, despite the substantial decline that has taken place over the years.

Human Development Index

Mortality is one of the basic components of population change and related data is essential for demographic studies and public health administration (Census of India; 2020). It is the principal ingredient for population projections and life tables. Information on death events recorded in SRS is used to estimate mortality indicators. The various measures of mortality published under SRS are Crude Death Rate (CDR), Under-five Mortality Rate (U5MR),

Infant Mortality Rate (IMR) and its components, Age Specific Mortality Rates (ASMR), Still Birth Rate (SBR) and Peri-Natal Mortality Rate (PMR).

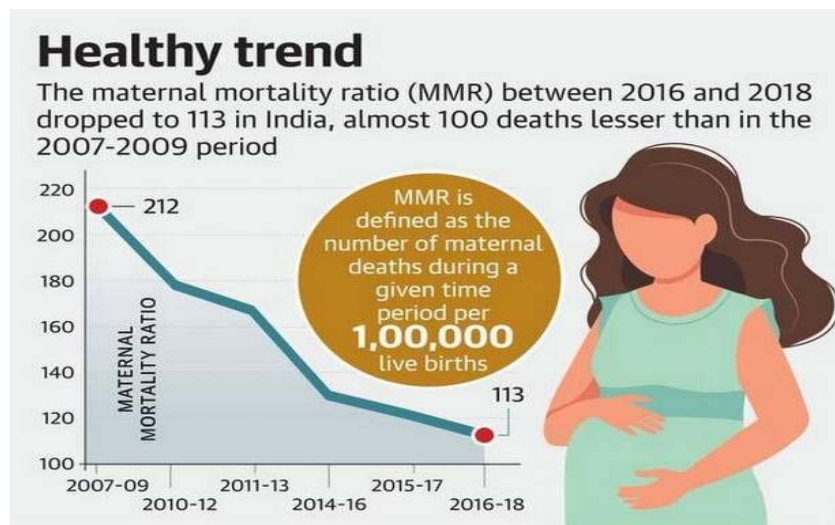
Chryssa McAlister, Thomas F. Baskett, (2006) the improvements in maternal mortality seen in the developed world during the 20th century have not been reflected in the developing world, where 98% of maternal deaths occur. Rates of maternal mortality in the developing world remain at 18th century levels despite increased international attention and aid. In more absolute numbers, approximately 600 000 women between the ages of 15 and 49 die each year as a result of complications of pregnancy and childbirth, and it is believed that this figure may be underestimated by 25%. This translates into a one in 16 chance of maternal death for a woman in Africa, while the risk is one in 4000 for a woman from Northern Europe. Furthermore, these numbers do not even take account of permanent disability and chronic illness that result from pregnancy-related complications, which are estimated to be 30 times higher.

Annandale, E. (2009) The dictum, 'women get sicker but men die quicker' is often treated as an established fact. However, historical demographic data demonstrate that women have not always outlived men. Moreover, current data from developing countries demonstrate that war, epidemic, disease and extreme poverty can diminish, or even reverse, women's advantage in life expectancy (see National Center for Healthcare Statistics, 2009; World Health Organization, 2008). Thus the apparently paradoxical gender differences in morbidity and mortality are neither universal nor invariant within and across societies (Annandale, 2009).

The HDI is a summary measure of three dimensions: (1) a long and healthy life, as measured by life expectancy at birth; (2) knowledge, as measured by the adult literacy rate (with 2/3 weight) and the combined primary, secondary, and tertiary gross education enrolment ratio (with 1/3 weight); and (3) decent standard of living, as measured by GDP per capita (PPP USD). For each dimension, an index was created with minimum and maximum values for each. Performance in each dimension is then expressed as a value. Maternal mortality rates in the 148 countries included in this report arise from data for each country dating from 1985 to 2001. These reported rates range between zero and 1800 deaths per 100 000 live births. Of the countries with low human development, the rates of maternal mortality range between 350 and 1800 deaths per 100 000 live births. Countries with high human development reported rates of maternal mortality ranging between zero and 130 deaths per 100 000, with most rates below 50 per 100 000.

Mortality and Health Trends of Women in India

The below picture shows the health trends in MMR of Women from 2016 to 2018 as we can see that MMR has dropped to 113 in India and it is an alarming trend found by the picture and surveys found by National Health Survey conducted in India.



Source: *The Hindu*, 17 July, 2020

The Maternal Mortality Ratio (MMR) in India has declined to 113 in 2016-18 from 122 in 2015-17 and 130 in 2014-2016, according to the special bulletin on Maternal Mortality in India 2016-18, released by the Office of the Registrar General's Sample Registration System (SRS). *The Hindu* (2020) One of the key indicators of maternal

mortality is the MMR, defined as the number of maternal deaths per 1, 00,000 live births. The target 3.1 of Sustainable Development Goals (SDG) set by the United Nations aims to reduce the global maternal mortality ratio to less than 70 per 1,00,000 live births. The MMR of various States according to the bulletin includes Assam (215), Bihar (149), Madhya Pradesh (173), Chhattisgarh (159), Odisha (150), Rajasthan (164), Uttar Pradesh (197) and Uttarakhand (99). The southern States registered a lower MMR Andhra Pradesh (65), Telangana (63), Karnataka (92), Kerala (43) and Tamil Nadu (60). “Maternal mortality in a region is a measure of reproductive health of women in the area. As per the World Health Organization, maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management,” noted the bulletin.

Amanat Khullar (2018) India’s preference for sons is not only preventing girls from being born, but is also causing higher mortality among girls who are born. A recent study published in Lancet Global Health has found that, on average, about 239,000 girls under the age of five die each year in the country because of their gender in part due to unwanted child-bearing and neglect. Selective abortion of female foetuses leads to fewer girls being born in the country, and foeticide and premature death of girls due to neglect add up to an estimated 63 million women “missing” from the population. While most studies highlighting gender bias in India have focused on prenatal mortality, a new study by the International Institute for Applied Systems Analysis (IIASA) is the first of its kind for focusing on excess under-five female mortality at the district level. ‘Excess’ mortality has been defined as the difference between observed and expected mortality rates in both genders. Excess female child mortality causing 2.4 million deaths in a decade has been observed in 90% of India’s districts and among 29 of the states and union territories, according to the study, whose conclusions its authors arrived at data from the 2011 Census. This rate among females could prevent India from achieving its Millennium Development Goal target on child mortality: 42 deaths per 1,000 births. Thus, while sex-selective abortions and excess female mortality in childhood might be a result from the same bias against female children, they are not observed in the same regions. The researchers gathered mortality data from 46 countries with no sign of gender bias to estimate the impact of excess female mortality in India’s districts. During the course of the study, from 2000 to 2005, 178,100 of the 13 million girls born died due to post-natal sex discrimination, a form of bias that largely remains “invisible”.

Maternal mortality ratio is the number of women who die from pregnancy-related causes while pregnant or within 42 days of pregnancy termination per 100,000 live births. The data are estimated with a regression model using information on the proportion of maternal deaths among non-AIDS deaths in women ages 15-49, fertility, birth attendants, and GDP. The following analysis of the maternal mortality rate in India is explained to understand the percentage of maternal mortality rate.

India maternal mortality rate for 2017 was 145.00, a 3.33% decline from 2016.

- India maternal mortality rate for 2016 was 150.00, a 5.06% decline from 2015.
- India maternal mortality rate for 2015 was 158.00, a 4.82% decline from 2014.
- India maternal mortality rate for 2014 was 166.00, a 5.14% decline from 2013.

It is very clear that since from 2014 maternal mortality rate in india has declined due to the health hazards and diseases spread by the natural calamities and climate change particularly with food habits of female population.

Mortality rate, adult, female (per 1,000 female adults) in India was reported at 147 % in 2018, according to the World Bank collection of development indicators, compiled from officially recognized sources.

Table No. 1: Sex Ration of Total Population and Child Population in the Age Group 0-6 and 7+ Years: 2001 and 2011 in India

Sl. No.	India/States/Union Territory #	Sex ratio (females per 1,000 males)					
		Total population		Child population in the age group 0-6		Population aged 7 and above	
		2001	2011	2001	2011	2001	2011
	1	2	3	4	5	6	7
1	INDIA	933	940	927	914	934	944
2	Jammu & Kashmir#	892	883	941	859	884	887

3	Himachal Pradesh	968	974	896	906	980	983
4	Punjab	876	893	798	846	888	899
5	Chandigarh	777	818	845	867	767	812
6	Uttarakhand	962	963	908	886	973	975
7	Haryana	861	877	819	830	869	885
8	NCT of Delhi #	821	866	868	866	813	866
9	Rajasthan	921	926	909	883	923	935
10	Uttar Pradesh	898	908	916	899	894	910
11	Bihar	919	916	942	933	914	912
12	Sikkim	875	889	963	944	861	883
13	Arunachal Pradesh	893	920	964	960	878	913
14	Nagaland	900	931	964	944	890	929
15	Manipur	974	987	957	934	977	995
16	Mizoram	935	975	964	971	930	976
17	Tripura	948	961	966	953	945	962
18	Meghalaya	972	986	973	970	971	989
19	Assam	935	954	965	957	929	953
20	West Bengal	934	947	960	950	929	946
21	Jharkhand	941	947	965	943	935	948
22	Orissa	972	978	953	934	976	985
23	Chhattisgarh	989	991	975	964	992	995
24	Madhya Pradesh	919	930	932	912	916	933
25	Gujarat	920	918	883	886	927	923
26	Daman & Diu #	710	618	926	909	682	589
27	Dadra & Nagar Haveli #	812	775	979	924	779	752
28	Maharashtra	922	925	913	883	924	931
29	Andhra Pradesh	978	992	961	943	981	997
30	Karnataka	965	968	946	943	968	971
31	Goa	961	968	938	920	964	973
32	Lakshadweep #	948	946	959	908	946	951
33	Kerala	1058	1084	960	959	1,072	1,099
34	Tamil Nadu	987	995	942	946	993	1,000
35	Puducherry #	1001	1038	967	965	1,006	1,047
36	Andaman & Nicobar Islands #	846	878	957	966	831	868

Source: Census of India, 2011.

Among the 36 State and Union Territories in Indian Union the Sex Ratio of Total Population and Child Population in the Age Group 0-6 and 7+ Years in the years 2001 and 2011 has explained in the Table No. 1. It is observed from the above table that the sex ratio of the total population and child population in the age group of 7 plus years has increased in India.

Girls Rights Platform (2020) The resolution adopted the United Nations on Gender Equity as well as Universal Declaration of Human Rights acknowledge about the recalling the Universal Declaration of Human Rights and the obligations of States parties to the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities, the International Convention on the Elimination of All Forms of Racial Discrimination and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families. UN has also acknowledged the decline of preventable maternal mortality in almost all regions, but noting with great concern the wide disparity among and within countries, with sub-Saharan Africa experiencing well above twice the global average level of maternal mortality, and that maternal mortality is generally highest in rural areas and in poorer and less-educated communities, including in informal urban settlements, recognizing the need to continue to raise awareness at the national, regional and international levels in order to stimulate greater efforts to reduce unacceptably high rates of

maternal mortality and morbidity, expressing deep concern that more than 350,000 women and adolescent girls still die every year from largely preventable complications related to pregnancy or childbirth, that adolescent girls face a higher risk of complications and death and that the average annual percentage decline in the global maternal mortality ratio still falls short of the figure of 5.5 per cent required to achieve the first target of Millennium Development Goal 5.

Sexuality and reproduction are central to women's health. Women's health during the reproductive or fertile years (between the ages of 15 and 49 years) is relevant not only to women themselves, but also has an impact on the health and development of the next generation. Many of the health challenges during this period are ones that only young girls and women face. For example, complications of pregnancy and childbirth are the leading cause of death in young women aged between 15 and 19 years old in developing countries. Globally, the leading cause of death among women of reproductive age is HIV/ AIDS. Girls and women are particularly vulnerable to HIV infection due to a combination of biological factors and gender-based inequalities, particularly in cultures that limit women's knowledge about HIV and their ability to protect themselves and negotiate safer sex. The most important risk factors for death and disability in this age group in low- and middle-income countries are lack of contraception and unsafe sex. These result in unwanted pregnancies, unsafe abortions, complications of pregnancy and childbirth, and sexually transmitted infections including HIV. Violence is an additional significant risk to women's sexual and reproductive health and can also result in mental ill-health and other chronic health problems.

Women around the world Most of the world's women live in low- or middle-income countries, almost half of them in the South-East Asia and Western Pacific regions. Only 15% of the world's 3.3 billion females live in high-income countries. More than one female in every three lives in a low-income country. Since low-income countries tend to have younger populations than high-income countries, one in every two children under nine years of age lives in a low-income country. By contrast, one in three women aged 60 years or more lives in a high-income country. High-income countries have the largest proportions of population aged 60 years or more.

Table No. 2: Sex Ratio of India in comparison with Other Countries

Sl. No.	Country	Sex Ration
1	World	984
2	Russian Federation	1,165
3	France	1056
4	Japan	1054
5	Germany	1038
6	United Kingdom	1037
7	Brazil	1031
8	South Africa	1028
9	United States of America	1026
10	Republic of Korea	1020
11	Australia	1011
12	Ethiopia	1010
13	Indonesia	1003
14	Nigeria	995
15	Malaysia	970
16	Iran	968
17	India*	940

Source: World Population Prospects (midyear estimates, 2010 revision, Sex and age United Nation)

* Sex ratio as per Provisional Result, Census 2011

As per the provisional results of Census 2011, total population of India is 1,21,01,93,422 which comprises of 62,37,24,248 males and 58,64,69,174 females with the sex ratio of 940 (Table No. 2) females per 1000 males. Madhya Pradesh has a total population of 7,25,97,565 with 3,76,12,920 males and 3,49,84,645 females with sex ratio of 930. States/Union Territories which account for the highest (Table No. 3) and lowest (Table No. 4) sex ratios in the country are mentioned in the respective tables and found that the southern states sex ration has increased where as northern states in India has not increased in sex ration. As per Census 2011, top five states/Union

territories which have the highest sex ratio are Kerala (1,084) followed by Puducherry (1,038), Tamil Nadu (995), Andhra Pradesh (992) and Chhattisgarh (991). Five states which have the lowest sex ratio are Daman & Diu (618), Dadra & Nagar Haveli (775), Chandigarh (818), NCT of Delhi (866) and Andaman & Nicobar Islands (878).

Table No. 3: Top five Highest States/UTs by sex ratio – 2011

Sl. No.	State/UT	Sex Ratio (females per 1000 Males)
1	Kerala	1084
2	Puducherry	1038
3	Tamil Nadu	995
4	Andhra Pradesh	992
	Chhattisgarh	991

Source: Census of India, 2011

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Table No. 4: Top five bottom States/UTs by sex ratio – 2011

Sl. No.	State/UT	Sex Ratio (females per 1000 Males)
1	Daman & Diu	618
2	Dadra & Nagar Haveli	775
3	Chandigarh	818
4	NCT of Delhi	866
	A & N Islands	878

Source: Census of India, 2011

Vital rates among males and females indicates that the Infant Mortality Rate (IMR) among female child is 68 which is higher compared to 66 in male child and the death rate among the male population is 8.5, higher compared to 8.4 in female population, which indicates that survival rate among the female population in higher age groups is slightly better compared to male population in the same age group. These variations in rates may have an impact on sex ratio both for total population as well as child population in the age (0-6 years).

Table No. 5: Mortality Rate in India 2018, by Gender

Sl. No	Year	Male	Female
1	2008	228.8	167.03
2	2009	227.03	162.48
3	2010	225.26	157.93
4	2011	223.49	153.38
5	2012	221.72	148.83
6	2013	219.36	146.3
7	2014	217	143.78
8	2015	214.64	141.25
9	2016	212.28	138.73
10	2017	209.92	136.2
11	2018	203.62	147.16

Source: Statistica.com, 2020

According to Plecher (2020), "the adult mortality rate is the probability of dying between the ages of 15 and 60 - that is, the probability of a 15-year-old dying before reaching age 60, if subject to age-specific mortality rates of the specified year between those ages." The Table No. 5 shows the adult mortality rate in India from 2008 to 2018, by gender. According to the source, the adult mortality rate is the probability of dying between the ages of 15 and 60 - that is, the probability of a 15-year-old dying before reaching age 60, if subject to age-specific mortality rates of the

specified year between those ages. In 2018, the mortality rate for women was at 147.16 per 1,000 female adults, while the mortality rate for men was at 203.62 per 1,000 male adults in India.

Mortality is one of the basic components of population change and related data is essential for demographic studies and public health administration. It is the principal ingredient for population projections and life tables. Valmiki Rama Krishna et al. (2016) Assuring public health services is primary duty of every government and as such, the government has taken steps to maintain public health, by opening health centres, hospitals, mobile hospitals, organizing mass awareness camps on health and so on. Many of the weaker groups such as women and children are prone to many types of illness, due to which even there is death of these women and children. Deaths of mothers during the pregnancy or after delivery are identified as maternal mortality. Similarly, due to different problems, if new born child is dead or death after delivery, it is called as infant mortality. Many of the reasons are causing for maternal mortality and infant mortality in India. Infant mortality rate is an excellent indicator of the socio-economic development of a country. India is facing severe problems related to the infant mortality.

Conclusion

Health inequalities between and within countries is a matter of growing concern internationally. Thus, the maximal regional life expectancy gap in India constituted about 21 years. Life expectancy differentials are even more striking in case of socio-economic status as the mortality burden falls disproportionately on economically disadvantaged and lower-caste groups. Maternal mortality is widely acknowledged as a general indicator of the overall health of a population, of the status of women in society, and of the functioning of the health system. High maternal mortality ratios are thus markers of wider problems of health status, gender inequalities, and health services in a country. The maternal mortality ratio is therefore useful for advocacy purposes, but lacks information on the causes of high maternal mortality or the interventions required to reduce maternal deaths. There is increasing global evidence that poor-quality health care is a major driver of excess mortality across conditions, including neonatal mortality. Poor-quality health care across the continuum of care from pregnancy to delivery has also been reported from India. For example, the Janani Suraksha Yojana programme in India, the world's largest demand-side financial incentive programme that provided cash incentives for women to deliver in health facilities, is reported to have significantly increased coverage of facility births but with variable improvements in maternal and new born survival, as many births occur in facilities that do not have sufficiently skilled staff to address maternal and new born complications. The lack of studies on all-age and adult mortality in India and many other developing countries can be explained by several specific problems related to the registration of adult mortality. In general, reliable mortality statistics require fully functioning vital registration systems.

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